Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARISA INIGO, MD
3100 TIMMONS LN, STE 250
HOUSTON, TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-09-A064-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary from Table of Disputed Services: "This claim was billed according to TDI-DWC Medical Fee Guidelines. Carrier needs to pay remaining balance as the claim has been sent to the carrier as a request for reconsideration and no additional payment made."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor submitted an initial bill to Texas Mutual where it was received 1/21/09.(Exhibit 1) The requestor submitted a duplicate bill to Texas Mutual where it was received 5/19/09. (Exhibit 2) As one can see from the documents in Exhibit 2 the bill is identical to that in Exhibit 1. Further, there is no annotation or narrative anywhere in the documents submitted with the duplicate identifying this was an appeal. The bill marked "REQUEST FOR PAYMENT" found in the requestor's DWC-60 packet has not been received by Texas Mutual. Further, the requestor submitted proof of submission of the initial bill but no proof the requestor submitted the bill marked "RECONSIDERATION FOR PAYMENT" to Texas Mutual.

Response Submitted by: Texas Mutual Insurance Co, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2008	99456 W5 WP	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §133.250 sets out the procedures for health care providers for Reconsideration for Payment of Medical Bills.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 11, 2009
   - CAC-W1- Workers Compensation State Fee Schedule Adjustment.
   - 790- This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

   Explanation of benefits dated June 10, 2009
   - CAC-18- Duplicate Claim/Service.
   - CAC-29- The time limit for filing has expired.
   - 224-Duplicate Charge.
   - 731-134.801 and 133.20 Provider shall not submit a medical bill later than the 95th Day after the date of service, for service on or after 9/1/05.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20 and 28 Texas Administrative Code §133.250?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code §408.027 and Texas Administrative Code §102.4 and 28 Texas Administrative Code §133.250?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Tex. Admin. Code §133.20(b) states in pertinent part "Except as provided in Labor code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that §408.0272 applies to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. 28 Texas Administrative Code §133.250 (c)(2) states in part, "A health care provider shall not submit a request for reconsideration until: …the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier." Review of the submitted documentation by the Requestor finds a copy of a fax verification report dated January 21, 2008, a Request for Reconsideration/Appeal letter dated May 12, 2009, copy of a certified mail receipt signed on May 19, 2009 by Respondent, a copy of two Explanation of Benefits with audit dates 02/11/209 and 06/10/2009. Further review of the letter requesting reconsideration dated May 12, 2009 states that although the Requestor received partial payment, an EOB/EOR was not attached and therefore, they were requesting a copy of the EOB/EOR and payment of the remaining balance. Documentation found supports that the Requestor submitted the initial bill within 95 days from the date services were rendered and appropriately filed a Request for Reconsideration in accordance with 28 Texas Administrative Code §133.250 (c)(2).
3. In accordance with 28 Texas Administrative Code §133.250 (c)(2), the Division concludes that the reconsideration bill was denied inappropriately as "duplicate claim/service" by the Respondent. The Requestor's documentation supports the services rendered. Therefore, reimbursement is recommended per 28 Texas Administrative Code §134.204.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.